The Quality Improvement and Innovation Partnership (QIIP) Learning Collaborative – Building a Learning Community to Improve Primary Healthcare

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I Introduction

Imagine a health care system where:

- You can get a "same day" appointment with your own physician.
- You are seen promptly when you arrive in your healthcare clinic.
- You have a central role in managing your own illness and are provided with the tools and education required to do so.
- You receive reminders from your primary healthcare provider about important screening tests and necessary follow-up visits.~ * ~ * ~ * ~ * ~ * ~ * ~ * ~ * ~ * ~ * ~ *~
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II Overview

Across Ontario, 120 teams of primary healthcare providers are redesigning how they deliver services to provide this kind of care. The teams are implementing changes that focus on improved access, chronic disease management and health promotion and illness prevention. Their overall goal is the achievement of improved clinical, functional and population health outcomes. Representing Family Health Teams (FHTs) and Community Health Centres (CHCs) from a broad spectrum of communities, these practitioners are participating in a Learning Collaborative that is supported by the Quality Improvement and Innovation Partnership (QIIP).

FHTs were established by the Ontario government in 2005, in response to several challenges. These included increasing difficulties in accessing primary healthcare and a well documented gap between evidence-based practice and current practice in chronic disease management, health promotion and disease prevention. To date, The Ministry of Health and Long Term Care (MOHLTC) has authorized 152 FHTs in three waves, with the expectation for additional growth in the future. The mission of these FHTs is to improve access to effective, comprehensive, patient-centred, team based primary health care. Key components of this approach include self-management, health promotion and illness prevention, and enhance the management of individuals with chronic diseases. The FHTs are expected to develop high quality programs that are well linked with other local health and community programs.

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III The role of the Quality Improvement and Innovation Partnership

The MOHLTC recognized that the shift from traditional reactive health service delivery to a new model of proactive primary care would present significant challenges. QIIP was created as part of the strategy to assist Ontario's new FHTs in negotiating this transition and to support them as they work to:

- establish strong organizations
- develop effective teams
- deliver high quality care.To provide this support QIIP employs three main strategies that include developing networks, practice supports and improvement methods. The QIIP Learning Collaborative was initiated following an exploration of the experience of other provinces and jurisdictions on how best to support the introduction of a quality improvement agenda designed to help FHTs improve clinical outcomes and office efficiency. A summary of evidence regarding the effectiveness of quality improvement collaboratives in healthcare is provided in a recent systematic review published in the British Medical Journal (Schouten et al 2008).

The Learning Collaborative will enable FHTs to improve the care they provide. Teams will learn to utilize Ontario's Chronic Disease Prevention and Management Framework (an adaptation of Wagner's Chronic Care Model which is a

framework for identifying areas where changes can be made in a system of care) and an adult learning model based on the Breakthrough Series Model, developed by the Institute for Healthcare Improvement (IHI), a Boston based not-for-profit organization dedicated to accelerating the transformation of health care globally. The Breakthrough Series Collaborative model has been applied internationally as a vehicle to accelerate change. This approach provides a mechanism to accelerate transformation through a structured peer-based collaborative learning approach. The aim of the collaborative will be to employ the Breakthrough Series Learning Model to improve the care of participating FHT teams' rostered patients by achieving certain goals in defined key measures.

FHTs were invited to join one of three collaboratives launched during 2008/09. Through an agreement with the Association of Ontario Health Centres (AOHC), CHC's were also given the opportunity to participate.

Each of the three collaboratives is utilizing an adaptation of the IHI Breakthrough Series Model. The model has been successfully adapted in other Canadian provinces. (A detailed description of the model is available on the QIIP website - see the Resources section for more information)

The model includes several important design attributes including:

- Use of evidence-based change packages that allow FHTs to focus on easily implementable opportunities for improvement.
- Structured monthly reporting on a common core set of measures.
- Technical assistance from expert faculty and subject matter experts as well as from practice facilitators in the field.
- The use of web-based technology to assist in communication and shared learning among the various FHT's and to support a knowledge management portal where resources, reports, and documentation of best practices can be housed and shared.
- Monthly teleconferences and periodic face-to-face learning opportunities to accelerate learning and adaptation of concepts to the local environment.The aim of the collaborative will be to employ the Breakthrough Series Learning Model to improve the care of participating FHT teams' rostered patients by achieving certain goals in defined key measures by May 2010.

Each organization participating in the Learning Collaborative has formed a Quality Improvement Team (QI team) comprised of a physician, registered nurse or nurse practitioner, other health professionals, and an administrative support staff member. The QI team members attend all learning sessions, oversee the process of change, review data, ensure key components of change are in place and manage changes within the organization.

The learning collaboratives are focused around several face-to-face learning sessions. In between the structured learning sessions are "action periods." During action periods, teams use the (Chronic) Care Model and the Model for Improvement to re-design and improve their care delivery systems and to imbed principles of health promotion and disease prevention into their day-to-day practice. The Model for Improvement is a strategy for testing, implementing, and spreading practice innovations. It includes the use of plan-do-study-act (PDSA) cycles or rapid cycle improvement. The Care Model is a framework for an ideal system of healthcare for chronic conditions. Consisting of six essential components, the model can also be applied to preventive care. The six essential components, or fundamental areas are:

- Self-management
- Decision support
- Delivery system design
- Clinical information system
- Organization of health care
- Community.During the Learning Collaborative, QIIP also assists the teams by providing practice facilitators who have expertise in quality improvement and change management. The practice facilitators provide on-site support and are available by telephone and email on a day-to-day basis.

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IV Areas of Focus

The efforts of teams participating in the Learning Collaboratives are focused on three topic areas that represent a proxy for the ability of FHTs to handle acute, chronic and preventive issues in an efficient and patient centred manner. The three topic areas are:

- diabetes management (clinical care)
- colorectal cancer (prevention)
- access and efficiency (office practice redesign - organizational change).
- The three topics reflect provincial priorities and have been identified through research and experience as needing improvement. Diabetes and colon cancer are two areas where there is room for significant improvement. Although we

know the positive impacts that lifestyle and evidence-based care can have in the diabetic population, it is estimated that:

- 60% of people with diabetes have gone more than a year without an eye exam.
- More than 50% of type 2 diabetics are not at recommended blood glucose targets.
- Less than 50% of type 2 diabetics are tested for A1c levels, blood pressure, cholesterol, or kidney function.Despite colon cancer being 90% curable, Ontario has one of the highest colon cancer death rates in the world. Of the Ontarians eligible for colorectal cancer screening in 2004-2005, only 17% received screening with a fecal occult blood test. Of the estimated 7800 colon cancers that were detected in 2007, more than 3200 will prove to be fatal, mostly because of late detection. A gap exists between what we know and what we practice. These disease and primary prevention outcomes are symptomatic of a system overtaxed with acute care needs in addition to the burgeoning demand for chronic and preventive care. The mission of the QIIP Learning Collaboratives is to close these gaps and get better clinical outcomes.

The Learning Collaborative's third topic for improvement is the domain of office practice redesign. It is important to develop more efficient ways to deliver care in order to move to a model of more proactive, planned care, and to optimize utilization of the team-based care that is a core component of both FHTs and CHCs. The Learning Collaborative assists teams in thinking about how to improve access to the care of the primary provider and other team members. Using principles that include open access, cycle time and continuity, the QIIP teams are learning to improve the flow of work, create efficiencies and balance supply and demand. The Learning Collaborative process targets improved outcomes in access and efficiency and is geared to creating a work environment where providers can "do today's work today" so that patients have timely access to the care they need.

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V Lessons Learned

Throughout the Learning Collaborative, teams have the opportunity to interact with each other, with the practice facilitators, and with the Collaborative leadership through learning sessions, listservs, conference calls, a web site for the Collaborative, a virtual office, and sharing of reports. The listserv and virtual office provide a mechanism for sharing tools and lessons learned, obtaining answers to questions, generating ideas for removing barriers, and identifying resources. Learning from one another is a powerful way for teams from across the province to build a learning community where "everyone learns, everyone teaches". As well, teams are learning to use data to monitor their improvement efforts and once per month, team and aggregate progress are assessed through the review of the core collaborative measures and narrative summary reports prepared by the teams. Teams are also developing strategies for spread and sustainability. This will enable them to spread their learnings and improvements from the improvement model to all areas of practice and to engage their co-workers who were not part of the QIIP team in the process. Examples of the QIIP work including the charter for the QIIP Learning Collaborative are available on the QIIP website (see Resources section).

Imbedding the principles of the Chronic Disease Prevention and Management Framework and the Model for Improvement into primary healthcare practice has the potential to improve the quality of life for both patients and providers. By equipping teams with the knowledge and expertise to apply rapid cycle tests of change and measurement into their day-to-day work, healthcare practitioners will have the tools they need to drive improvement now and into the future.

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VI Conclusion and Call to Action

As QIIP gets ready to welcome 50 new teams to the third Learning Collaborative that began at the end of March 2009 there is growing excitement about the continued potential of the Learning Collaborative methodology as a means to implement quality improvement in primary healthcare.

Some teams are already reporting significant improvements in their colorectal screening and diabetes mellitus measures and are sharing their successes with their networks. The QIIP Learning Collaborative provides an excellent opportunity for other practitioners to understand the potential for improved access and outcomes within the context of the Ontario environment.

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VII References

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2 Health Council of Canada "Why Health Care Matters, Lessons Learned From Diabetes, March 2007.

3 Quality Improvement and Innovation Partnership Website at http://www.qiip.ca.